Center for Medicare Advocacy
MedicareAdvocacy.org

Response to July 2023 CMS Request for Information (RFI): Eight Questions Addressing Access to Home Health Aide Services

EXECUTIVE SUMMARY

Introduction (RFI Response, page 1)

Home health services as authorized by Medicare law, regulation and policies are increasingly unavailable in practice. For patients who meet qualifying criteria, Medicare law authorizes up to 28-35 hours a week of home health aide and nursing services combined. Unfortunately, in practice, patients can rarely access even a fraction of these Medicare-covered aide services.

Barriers to aide services have decimated access to this care. These barriers include the following:

1. CMS and HHA policies and practices have created disincentives to provide aide services.
2. There is competition in other care settings for available aides.
3. HHAs contend that aides are not available.

The full extent of barriers to aide services cannot be fully discerned until CMS takes affirmative steps to remedy current discriminatory policies and practices that discourage the provision of aide services to individuals with chronic and longer-term conditions.

RFI Question 1 - Why is utilization of home health aides continuing to decline as shown in Table B2 and Figure B4 if the need for these services remains strong? (RFI Response, pages 2-9)

1. Aide utilization by HHAs is declining, but patient need for aides is not declining.

2. Despite the precipitous decline in aide services provided by HHAs, Medicare beneficiaries need, and qualify for, aide services.

3. The decline in the provision of Medicare-covered aide services has been exacerbated by a combination of factors that were initiated by CMS decades ago and steadily eroded HHA hiring and the availability of aide services over time, including:

   A. Adapting to CMS audit and compliance systems,
   B. Maximizing profitability outcomes from quality and value-based purchasing incentive measures,
   C. Responding to CMS payment reforms,
   D. Capitalizing on the most profitable patient mix,
   E. Refusing to provide services to patients with conditions that require more resources,
   F. Strategically keeping aide staff low in Medicare-certified agencies while increasing aide staff in related business affiliates,
   G. Requiring family caregivers to perform aide tasks, in violation of Medicare policy and the Medicare Conditions of Participation,

H. Disrespecting the value and contributions of home health aides, in violation of the Medicare Conditions of Participation,
I. Having the advantage of an administrative appeals system that provides patients with no practical recourse for improperly denied services, and no repercussions to HHAs.

4. Additional Aide Utilization Concerns That May Impact HHAs, as Stated by HHAs to the Center for Medicare Advocacy:
   - Medicare dependent services, including aides and medical social services are "not required" services for HHAs to be enrolled in Medicare.
   - Medicare payment is only for "skilled" work.
   - Original Plans of Care are revised to reduce or remove Medicare-covered aide hours when HHAs inform authorized providers that aide hours are not available.
   - Messaging from "trusted sources" (MedPAC, SSA, MACs, OIG) is negative, or incorrect, and diminishes HHA aide utilization:
   - Patient surveys, known as HHCAHPS (Home Health Care Consumer Assessment of Healthcare Providers and Systems), are inadequate to evaluate a lack of services.
5. There is increasing competition for a limited number of available aides in the job market.

RFI Question 2 - To what extent are higher acuity individuals eligible for Medicare (for example, individuals with multiple comorbidities or impairments of multiple activities of daily living) having more difficulty accessing home health care services, specifically home health aide services? (RFI Response, pages 8-9)

1. Individuals who require more care (higher acuity) have more difficulty accessing home health care in general, and aides in particular.
2. Lack of aide services impacts individuals with chronic and longer-term conditions more significantly than individuals with shorter-term and post-acute care needs.
3. As use of aides by HHAs has declined over time, payment for aides has been virtually eliminated from the base PGDM calculation.
4. HHAs face no repercussions when they fail to provide aide services.
5. HHAs that provide fewer services, including aides, are lauded and less likely to be audited, while HHAs that serve higher acuity individuals are more likely to be penalized and audited.

RFI Question 3 – What are notable barriers or obstacles that home health agencies experience relating to recruiting and retaining home health aides? What steps could home health agencies take to improve the recruitment and retention of home health aides? (RFI Response, pages 11-13)

Current barriers for recruiting and retaining home health aides:

- Aides being provided to those who can pay privately or through Medicaid payment,
- Restrictive immigration policies that do not focus on the need for aide services,

- Low compensation, relative to other available support jobs in the economy,
- Competition (demand high relative to supply) for aide-type labor in the economy,
- Minimal opportunities for job and career/managerial growth,
- Potentially long travel times between clients,
- Aides are rarely consulted or included in development of patient care plans,
- Physically, psychologically, and emotionally difficult and stressful work,
- Higher-than-average injury rates,
- Limited training,
- Unfulfilling work – home health aides currently performing an overly limited set of tasks.

Recommendations to improve recruitment and retention:

- Increase compensation and improve plans for sustained growth and job security at HHAs,
- Engage aides more fully in the plan of care; recognize aides as highly-valued,
- Provide ongoing advanced training and job development,
- Create a centralized training delivery system with options for customization,
- Support aide work and participation on the home health team more respectfully,
- Grow the available work force through more supportive policies, including immigration,
- Identify ways to take the pressure off competition for aides-type occupations,
- Encourage and train individuals who may not be currently working,
- Decrease travel time by recruiting aides in geographical areas where patients are located,
- Allow aides to engage in all Medicare covered aide services needed by the patient,
- Review State Data Center on the Direct Care Workforce information.

RFI Question 4 – Are HHAs paying home health aides less than equivalent positions in other care settings (for example, are aides in the inpatient hospital setting or nursing home setting paid more than in home health)? What are the reasons for the disparity in hourly wages or total pay for equivalent services? (RFI Response, pages 13-14)

According to the U.S. Bureau of Labor Statistics Occupational Outlook Handbook, the median salary for a nursing assistant in a health care facility as of May 2021 was $30,310 per year. The median salary for a home health aide as of May 2021 was $29,430.

- In facilities, assistants/aides are typically employed to be physically present there,
- Work in the facility may be more personally rewarding for the assistant/aide,
- There is more personal security for an aide in a facility than in a home, as there is typically other staff present,
- Similarly, there is greater personal support and safety for an aide in a facility.
- General working conditions in facilities may be more fully supported for aides to pursue additional career growth, receive stronger benefit packages, and be represented through unions.
- Aides may be able to have a more flexible schedule with a home health agency.

RFI Question 5 – In what ways could HHAs ensure that home health aides are consistently paid wages that are commensurate with the impact they have on patient care that they provide to Medicare beneficiaries? (RFI Response, pages 14-15)

1. Aides and the services they provide must be valued as an important component of the home health care for patients.
2. HHAs must have affirmative incentives to provide aides, PPS systems have not worked, and CMS has not adopted an appropriate case-mix calculation within PPS to give HHAs a financial incentive to staff for/provide aide services.
3. CMS should explore alternate ways to compensate agencies when they provide necessary aide services and CMS should require accountability to ensure compensated aide services are delivered.

RFI Question 6 – How effective is the coordination between Medicare and Medicaid to ensure adequate access to home health aide services? Please share insights on the level of utilization of Medicaid benefits by dually eligible beneficiaries for additional home health aide services that are not being provided by Medicare. (RFI Response, pages 15-16)

- Medicare insures approximately 65 million beneficiaries. About 18% of beneficiaries are dually eligible for Medicare and Medicaid.
- Of beneficiaries who are dually eligible, coordination between Medicare and Medicaid for aide services appears to be non-existent for traditional Medicare and Medicare Advantage plans.
- Aide services are consistently more available for dually eligible individuals than for non-dually eligible individuals.
- One reason dually eligible individuals may receive more aide/assistant services is that additional services (beyond Medicare-covered personal hands-on care) are covered by Medicaid.
- Entire PDGM payments are retained by the HHA for the provision of skilled services, and the HHA also claims Medicaid coverage for aide/assistant time.
- In some states, obtaining Medicaid payment for home health aide and other services is less complicated and time-consuming than Medicare.

RFI Question 7 – Are physicians' plans of care less reliant on home health aide services than in the past, or are HHAs less willing/able to provide these services? If so, what are the primary reasons why such services are not provided? (RFI Response, pages 16-18)

The answer is that both of these problems are occurring.

- Physicians' (allowed practitioners') plans of care are less inclusive of home health aide services than in the past, because HHAs have made it clear that aide services are generally very limited or not available and it is futile to request them,

- In order to avoid having a request for all services rejected, many allowed practitioners have reduced or eliminated requests for aide services,
- Beneficiaries often tell the Center for Medicare Advocacy, that HHAs are less willing to provide aide services, often requiring family caregiving commitments prior,
- HHAs regularly ignore Medicare policy that caregivers must be willing and able to provide aide services to patients,
- HHAs refuse to initiate services unless the family agrees to be "taught" to perform aide services,
- HHAs refuse to staff, or they under-staff, aides.

RFI Question 8 – What are the consequences of beneficiary difficulty in accessing home health aide services? (RFI Response, page 18)

Almost every day, staff at CMA hear near-crisis stories from home health qualifying beneficiaries and family members who are frustrated – sometimes panicked – due to their inability to find Medicare-covered aide services. They cannot understand when we explain that Medicare law covers aides, but they typically aren't available from Medicare-certified HHAs.

Here are some of the personal and societal consequences for our clients:

- Unnecessary hospitalizations and nursing facility admissions,
- Inability to remain safely in the community,
- Further medical complications, including:
    - Infections, UTI, skin breakdown from lack of hygiene, care assessment, movement. Etc.,
    - Falls,
    - Lack of critical medication and exercise assistance,
    - Stress-related health concerns,
    - Hunger and malnutrition,
    - Depression, feeling like a burden on family and caregivers, other mental health problems,
- Forced institutionalizations due to lack of assistance in the home,
- Strained and broken family relationships, as family members need to work and cannot be forced into caregiving activities,
- Damage to children when household adults are unable to get necessary care.
- Loss of dignity and quality of life.
- Feeling unsupported by a Medicare program they depended on and that has failed them.

Conclusion, Survey and Resources (RFI Response, pages 19-23)